

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013761

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3564 STATE FILE NUMBER

**FILED APR 8 1963**

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		Length of stay in 1b <u>9 Days</u>	c. CITY OR TOWN <u>Louisiana</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1120 South Carolina</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES Percy Rose</u>			4. DATE OF DEATH Month Day Year <u>3 25 63</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/1895</u>
9. AGE (last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	11. BIRTHPLACE (City and state or country) <u>Louisiana, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles B. Rose</u>	
14. MOTHER'S MAIDEN NAME <u>Mae Estelle Clapp</u>		15. NAME OF HUSBAND OR WIFE <u>Gail Smith Rose</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. I</u>		17. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause, (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		DUE TO (c) <u>4201</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>no</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour s.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3/21/63</u> to <u>death</u> and last saw her/him alive on <u>3/25/63</u> Death occurred at <u>11:58 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert Paine M.D.</u>		22b. ADDRESS <u>5535 Delmar</u>	
22c. DATE SIGNED <u>3/26/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/29/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Louisiana, Missouri</u>	
24. FUNERAL DIRECTOR <u>Geo. M. Collier, Louisiana, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 28 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>			

APR 8 1963

APR 3 1963

JUN 4 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Mrs M. Collier*

Licensed Embalmer No.

*3829*

P. O. Address

*Louisiana, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.